STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
155377		B. WING		03/01/2012	
NAME OF I	PROVIDER OR SUPPLIE	D.	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIE	K.	707 S	JACKSON PARK DR	
SEYMOU	JR CROSSING		SEYMO	OUR, IN 47274	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
			F0000		
	This wisit was fo	on the Investigation of	1 0000	PREPARATION AND/OR EXECUTION	,
		or the Investigation of		OF THIS PLAN OF CORRECTION IN	
	Complaint IN00	0103299.		GENERAL, OR THIS CORRECTIVE	
	G 11 . P.20	102200 G 1		ACTION IN PARTICULAR, DOES NOT	·
	_	103299-Substantiated.		CONSTITUTE AN ADMISSION OR	
		ficiencies related to the		AGREEMENT BY THIS FACILITY OF	
	_	ited at F309, F425 and		THE FACTS ALLEGED OR	
	F514.			CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES.	
				STATEMENT OF DEFICIENCIES.	
	Survey dates: Fe	ebruary 29 and March 1,		The plan of correction and specific	
	2012			corrective actions are prepared	
				and/or executed in compliance	
	Facility number:	: 000272		with state and federal laws. The	
	Provider number	r: 155377		facility is requesting a DESK	• • • • • • • • • • • • • • • • • • •
	AIM number: 1	00274710		REVIEW of compliance for the plan of correction.	lis
				plan of correction.	
	Survey team:				
	Cheryl Fielden,	RN-TC			
	Janie Faulkner,	RN			
	<u> </u>				
	Census bed type	:			
	SNF/NF: 76				
	Total: 76				
	, , ,				
	Census payor ty	ne:			
	Medicare: 9	r - ·			
	Medicaid: 61				
	Other: 6				
	Total: 76				
	10tai. /0				
	Sample: 4				
	Sample: 4				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPI 03/01	LETED		
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	cited in accordar	es reflect state findings nee with 410 IAC 16.2.						
	Quality review c 2012 by Bev Fau	ompleted on March 6, ılkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM				ETED
		155377		03/01/	/2012		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
SEVMOL	ID CDOSSING				IACKSON PARK DR		
SETIVIOU	IR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	483.25						
SS=D		E/SERVICES FOR HIGHEST					
	WELL BEING						
		ust receive and the facility					
	·	e necessary care and					
	practicable physi	n or maintain the highest					
		II-being, in accordance with					
		ive assessment and plan of					
	care.						
			F03	09			03/31/2012
	Based on observe	ation, interview, and			E 200 Dravida		
					F-309 Provide		
	•	ne facility failed to ensure			care/services		
		ed an ordered wound care			care/services		
	•	note healing. This			for		
	affected 1 of 3 r	esidents reviewed for					
	wound care treat	ments in a sample of 4.			Highest well being.		
	(Resident # D)				What		
	·				_		
	Findings include	·d·			corrective		
	i manigs merade	u.					
	Th	esident # D was reviewed			action(s) will		
					bo		
		5 P.M. The resident had			be		
	an order with an	origination date of			Accomplished for those		
	11/26/11 to apply	y Santyl/Polysporin 1:3			residents Found to have been	en	
	ointment after cl	eansing right buttock			affected by the Deficient		
	wound with norm	nal saline, then to cover			practice: Resident D is		
		inate, and secure with a			receiving wound care treatment per Physician order	nt	
		The order was to change			l ' '		
	daily and as need				How will you identi	Іту	
	dairy and as need	icu.			other residents		
	0.0/00/00/0	1.00.00.1			Having the potential to be		
		1:28 P.M., the ADON			affected by the same deficien	nt	
	was observed pre	eparing for the wound			practice and what corrective		
	treatment for Res	sident # D. The ADON			action will be taken: · All		
	was observed to	unlock the treatment cart			residents receiving wound car		
	and opened two	drawers and stated, "no			treatments have the potential	to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
155377			NO		03/01/	2012	
AND PLAN	Summary S (EACH DEFICIEN REGULATORY OF Santyl and Polys treatment" "It sh from the pharma last." The ADON was sterile gauze pac saline, and algin cart. During obs the ADON clear	155377	A. BUILDI B. WING S 7 C	NG STREET AI	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR UR, IN 47274 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) be affected by the alleged deficient practice. • The licensurses will be in serviced by the DNS/designee 3/20/12 on administering treatments per order, and re-ordering medications/treatments. Post tincluded. • All residents receiving wound treatments has been reviewed to ensure that tordered treatment is available and that treatments have been completed per order evidenced.	COMPL 03/01/	ETED
	water, dried with	n sterile gauze, and placed			by initialed box. The directo nursing services/designee is	r of	
	1 ~	nd bed and covered the			responsible to ensure compliant What measures will be put	nce	
		erall dressing. The I do (resident's name)			into place or what systemic		
	· ·	s wound, it has really			changes you will make to		
		call the doctor and let			ensure the deficient practice does not recur: • The		
	•	't have the Santyl and			licensed nurses will be in servi		
	Polysporin for to	eatment and I'll call the			by the DNS/designee 3/20/12	on	
	pharmacy and as	sk them to send it so I'll			administering treatments per order, and re-ordering		
	have it for the tr	eatment tomorrow. This			treatments. Post test included		
	was not caused l	by pressure, it was caused			All residents receiving wound		
		nt bumped his right hip on			treatments have been reviewe ensure that wound treatments	d to	
	his wheelchair c	ausing tissue death."			have been documented as		
		2012.1			complete per order evidenced	by	
		nnuary 2012 Medication			initialed box. · Unit manager/designee will review	all	
		Record (MAR), lacked			meds/treatments ordered from		
		of the wound treatment			pharmacy daily to ensure		
		on January 5 and the			delivered timely. Meds/treatments found not to	he	
	Administration	pary 2012 Medication			delivered- a call to the pharma		
		he wound treatment was			will be made to stat the order of	or	
		ebruary, 7, 17, and 21.			call into the back-up pharmacy	'. ·	
	Completed on re	voruary, 7, 17, and 21.			The director of nursing services/designee is responsible.	ole	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155377	A. BUILDING B. WING	COMPLETED 03/01/2012
	PROVIDER OR SUPPLIER JR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the ADON on 2/29/2012 at 1:45 P.M., she indicated that if the treatment is done, it should have the nurse's initials or signature. If not done the nurse is supposed to circle the date and note on the back the of medication administration record and in nurse's note the resident refused treatment or the medication for treatment was not available. The only documentation on the treatment record and nurse's note was from the ADON on 2/29/12 that indicated there was no Santyl and Polysporin for Resident # D's ordered wound treatment. This federal tag relates to Complaint IN00103299. 3.1-37(a)	to ensure compliance · Non-compliance will result in further education including disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · Unit manager/designee will review meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not the delivered- a call to the Pharmal will be made to stat the orde call into the back-up pharmal All residents receiving wound treatments will be reviewed using the CQI audit tool-Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, month months and for 2 quarters thereafter. · Findings from the CQI process and trends will reviewed monthly and an action plan will be implemented for threshold below 95%. Dat Compliance: 3/31/12	w all om o be macy r or cy. · d daily ally x 3 the be tion

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
155377		B. WING 03/01/201			03/01/2012		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER						
CEVMOL	ID CDOCCING				JACKSON PARK DR		
SETIVIOL	JR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0425 SS=D	PROCEDURES, The facility must emergency drug- residents, or obta agreement desci part. The facility personnel to adn	CAL SVC - ACCURATE RPH provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed hinister drugs if State law under the general					
	A facility must pr services (including the accurate acquired and administering biologicals) to mare resident.	licensed nurse. ovide pharmaceutical ng procedures that assure uiring, receiving, dispensing, g of all drugs and eet the needs of each					
	services of a lice provides consult	employ or obtain the nsed pharmacist who ation on all aspects of the macy services in the facility.	F04.	25	F-425 Pharmaceutical SVC –	- 03/31/2012	
	Pagad on observe	ation, interview, and			accurate procedures, RPH		
	· · · · · · · · · · · · · · · · · · ·	e facility failed to ensure					
	a resident's order	red medicated ointment					
	was available for	use to promote wound			What		
	healing. This affo	ected 1 of 3 residents			VVIIAL		
	reviewed for wor	and care treatment in a			corrective		
	sample of 4. (Re				Corrective		
	Sample of 4. (Re	sident # D)			action(s) will		
	D' 1' ' 1 1				action(3) will		
	Findings include	a:			be		
	on 2/29/12 at 3:4 an order with an	sident # D was reviewed 5 P.M. The resident had origination date of y Santyl/Polysporin 1:3			Accomplished for those residents Found to have been affected by the Deficient practice: Resident D is receiving wound care treatment per Physician order		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 6 of 11

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
155377			B. WIN	G		03/01/2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	ROVIDER OR SOLI EIER			707 S J	IACKSON PARK DR	
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
		eansing right buttock			How will you identi	fy
	wound with norn	nal saline, then to cover			other residents	
	with calcium alg	inate, secure with a clear			Having the potential to be	
	dressing. The or	der was to change daily			affected by the same deficier	nt
	and as needed.				practice and what corrective	
					action will be taken: All	
	On 2/29/2012 at	1:28 P.M., the ADON			residents receiving wound care	
		eparing for the wound			treatments have the potential t	0
	•	sident # D. The ADON			be affected by the alleged	
		unlock the treatment cart			deficient practice. • The licens nurses will be in serviced by the	
					DNS/designee 3/20/12 on	
	-	drawers and stated, "no			administering treatments per	
	Santyl and Polys	•			order, and re-ordering treatme	nts.
		ould have been reordered			Post test included. · All reside	
	from the pharma	cy by whoever used it			receiving wound treatments ha	
	last."				been reviewed to ensure that t	he
					ordered treatment is available and that treatments have beer	,
	The ADON was	then observed to remove			completed per order evidence	
	sterile gauze pad	ls, small bottle of normal			by initialed box. · The directo	
		ate from the treatment			nursing services/designee is	
	_	servation of the treatment,			responsible to ensure complia	nce
	_	sed the wound on right			What measures will be put	
		ize dressing and sterile			into place or what systemic changes you will make to	
	_	n sterile gauze, and placed			ensure the deficient practice	
		nd bed and covered the			does not recur: • The	
	_				licensed nurses will be in servi	ced
		erall dressing. The			by the DNS/designee 3/20/12	on
	•	do (resident's name)			administering treatments per	
		wound, it has really			order, and re-ordering	_
	improved. I will call the doctor and let				treatments. Post test included All residents receiving wound	
		't have the Santyl and			treatments have been reviewe	d to
	Polysporin for tr	eatment and I'll call the			ensure that wound treatments	
	pharmacy and as	sk them to send it so I'll			have been documented as	
	have it for the tre	eatment tomorrow."			complete per order evidenced	by
					initialed box. · Unit	
	The review of th	e Medication			manager/designee will review meds/treatments ordered from	
			1		I modora calmonia diacica ildin	ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 7 of 11

	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/01/2012
	PROVIDER OR SUPPLIER JR CROSSING	707 S J	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR DUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Administration Records for January and February of 2012, lacked documentation for wound care treatments to right buttock on January 5th and 27th and on February 7th, 17th, and 21st, 2012. This federal tag relates to Complaint IN00103299. 3.1-25(a)		pharmacy daily to ensure delivered timely. Meds/treatments found not to delivered- a call to the pharma will be made to stat the order call into the back-up pharmac. The director of nursing services/designee is responsi to ensure compliance. Non-compliance will result in further education including disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit manager/designee will review meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not to delivered- a call to the Pharma will be made to stat the order call into the back-up pharmac. All residents receiving wour treatments will be reviewed dausing the CQI audit tool-Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, monthly months and for 2 quarters thereafter. Findings from the CQI process and trends will be reviewed monthly and an actic plan will be implemented for threshold below 95%. Date Compliance: 3/31/12	acy or y ble all or be acy or y

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 8 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155377	B. WING 03/01/2012				2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CEVMOL	ID CDOCCING				IACKSON PARK DR		
SETIMOU	IR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0514	483.75(I)(1)						
SS=D	RES						
		IPLETE/ACCURATE/ACCE					
	SSIBLE						
		maintain clinical records on					
		accordance with accepted ndards and practices that are					
	•	ately documented; readily					
		systematically organized.					
	•	, , ,					
	The clinical reco	rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
	•	reening conducted by the					
	State; and progre		F0514				02/21/2012
		review and interview, the	F05	14	_		03/31/2012
	facility failed to	ensure complete and			-514		
	accurate docume	ntation in the clinical					
	record of one of	one resident reviewed for			Records-comp)I	
	complete and acc	curate records in a sample				_	
	of 4. (Resident #	-			ete/accurate/a	C	
	01 (1100140110	2)			cessible		
	Findings include	٨.			Cessible		
	rindings include	u.					
	D : 4	1 · C P · 1 · // P			What		
	· ·	d review for Resident # D			Villat		
		3:45 P.M., the review of			corrective		
	the Medication A	Administration Records					
	for January and I	February of 2012 lacked			action(s) will		
	documentation for	or wound care treatments			\ <u>_</u>		
	to right buttock on January 5th and 27th				be		
	•	7th, 17th, and 21st, 2012.			Accomplished for those		
	and on reordary	,, 1 ,, with 210t, 2012.			residents Found to have bee	en	
	The Ion 201	2 magamitulation =======			affected by the Deficient		
	-	2 recapitulation orders			practice: Resident D is		
		r, dated 11/26/11, for			receiving wound care treatmen	nt	
		n ointment: "cleanse area			per Physician order	_	
	on right buttock	with normal saline, apply			How will you identi	fy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 9 of 11

	OF CORRECTION OF CORRECTION 155377	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/01/2012	
	PROVIDER OR SUPPLIER UR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	ointment cover with calcium alginate secure with clear adherent dressing change daily and as needed." During an interview with the ADON on 2/29/2012 at 1:45 P.M., she indicated that if the treatment is done, it should have the nurse's initials or signature. If not done the nurse is supposed to circle the date and note on the back the of medication administration record and in nurse's note the resident refused treatment or the medication for treatment was not available. 3.1-50(a)(1) 3.1-50(a)(2)		other residents Having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents receiving wound care treatments have the potential be affected by the alleged deficient practice. The licentures will be in serviced by the DNS/designee 3/20/12 on administering treatments perforder, and re-ordering medications/treatments. Post included. All residents receiving wound treatments have been reviewed to ensure that ordered treatment is available and that treatments have been completed per order evidence by initialed box. The director nursing services/designee is responsible to ensure compliant what measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: The licensed nurses will be in service by the DNS/designee 3/20/12 administering treatments per order, and re-ordering treatments. Post test included All residents receiving wound treatments have been reviewed ensure that wound treatments have been documented as complete per order evidenced initialed box. Unit manager/designee will review meds/treatments ordered from	e to sed ne test ave the n d or of noce iced on t	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 10 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/01/2012
	ROVIDER OR SUPPLIER	707 S .	ADDRESS, CITY, STATE, ZIP CODE JACKSON PARK DR OUR, IN 47274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) SE COMPLETION DATE
			pharmacy daily to ensure delivered timely. Meds/treatments found not delivered- a call to the pharm will be made to stat the order call into the back-up pharma. The director of nursing services/designee is responsite to ensure compliance. Non-compliance will result in further education including disciplinary action. How to corrective action(s) will be monitored to ensure the deficient practice will not recur: Unit manager/designee will revie meds treatments ordered from pharmacy daily to ensure delivered timely. Meds/treatments found not delivered- a call to the Pharma will be made to stat the order call into the back-up pharma. All residents receiving woun treatments will be reviewed using the CQI audit tool-Medication / Treatment / Pharmacy Audit x 4 weeks, bi-weekly x 2 months, month months and for 2 quarters thereafter. Findings from the CQI process and trends will reviewed monthly and an action plan will be implemented for threshold below 95%. Da Compliance: 3/31/12	macy er or acy. sible h he w all om to be macy er or acy. d daily hly x 3 the be stion

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0LNK11

Facility ID: 000272

If continuation sheet

Page 11 of 11